CRCR Coaching Course
Unit 4: Post-Service – Financial Care

Session Speakers and Facilitator

Michelle Sinches, CRCR, CHFP, CSPR, CSAF
Senior Client Executive at OPTUM Provider Market

Sergio Quiej
Multi-State Division PFS Support Manager at AdventHealth

Tibor Bajusz, MBA, CRCR
Director of Growth at MDS

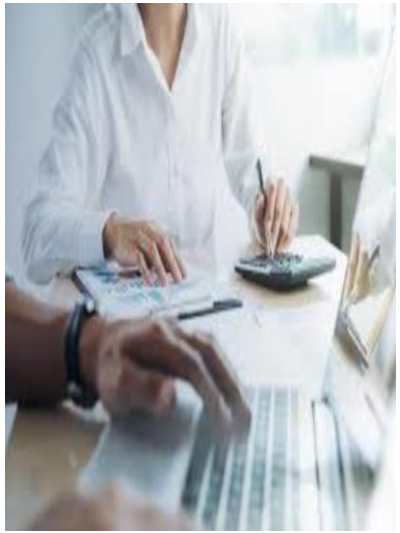
Unit 4: Post-Service – Financial Care

4.1: Cash Posting & Electronic Remittance Advice and Fund Transfers

- Recognize the required internal controls for cash posting.
- Classify the different types of general ledger cash (non-accounts receivable) and outline how it is posted.
- Recognize the general concepts of electronic funds transfers.
- Categorize the different levels of automation used in electronic remittance advice posting.

Cash Handling Controls

- Separation of cash handling procedures
- Internal Audits
- External Audits
- Reconciliation
- Multi Level Authorizations



Daily Reconciliation Process

- Obtains total of all payments
- Divide into batches for posting
- Endorse checks immediately
- Prepare the bank deposit for all payments
- Post cash and adjustments with specific codes
- Post unidentified payments to an unidentified account
- Balance and post batches
- Balance Payments to the bank deposit
- Balance the bank deposit to the General Ledger

General Ledger Cash

- What is general ledger Receipts?
- Logged, secured and receipts used
- Batched by payment type
- Totaled and documented
- Delivered to cashier and re-totaled
- Bank Deposit

Electronic Transactions

Electronic Funds Transfer (EFT)—

- The fastest way to move money because it is possible to transfer funds
- Greatly simplifies cash balancing and control requirements

835

Electronic Remittance Advice (ERA) 835 Data Set

- 835 format is used to electronically send third-party payments and remittance details to healthcare providers
- Level 1—Electronic receipt of data only
- Level 2—Electronic receipt and electronic data entry
- Level 3—Electronic receipt, data entry, reconciliation, posting, and closing
- Level 4—Total automation of receipt, data entry, payment posting and adjustment processing

Balancing and Control

- Download the Electronic Remittance Advice (ERA) files.
- Review payment amount with EFT payment amount.
- Process against system filters to identify items that require manual review:
- After resolving all filtered exceptions, execute automatic account posting.

Key Points

- EFT is the transfer of funds from payer to payee through the banking system.
- EFT is the fastest way to move money
- ERA is used to electronically send third-party payment details to healthcare providers.
- Balancing and Control .

What is EFT?

- A standardized healthcare claim payment/advice known as the 835 format.
- The establishment of internal audits by personnel outside the involved department.
- The electronic transfer of funds from payer to payee through the banking system
- A process that requires the separation of duties when processing patient payments.

Questions?

4.2: Credit Balances

- Define the term credit balance and identify the root causes and origins of credit balances in accounts receivable.
- Select resolutions to the most common errors resulting in a credit balance.
- Identify resolution processes to small credit balances.

Credit Balances

- Occur when payments and contractual adjustments posted to an account exceed the total charges
- Considered Liability
- Regulatory requirements

Reasons and Resolutions

- Incorrectly posted allowances or proration rules
- Charge credits after billing
- Duplicate payments
- Inaccurate upfront collections
- Primary and Secondary claim processing

Small Credit Balances

- Providers must ensure that their small credit balance policy does not violate any state statues or payer contract clauses concerning the disposition of credit balances.
- What is or is not done early in the process affects everything that happens later in the process.

Which statement is NOT true about credit balances?

- There are no CMS hospital compliance requirements regarding credit balances
- A small credit balance should be matched by a similar policy for small debit balances.
- Hospital generated statements should be sent to patients regarding small credit balances.
- Tracking reports should be developed to identify internal charge credits vs external charge credits.

Key Points

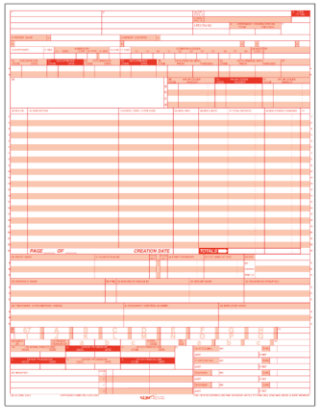
- Credit balances occur in accounts receivable when payments and contractual adjustments posted to an account exceed the overall total charges.
- Credit balances should be identified and resolved to prevent the healthcare organization’s accounts receivable amount from being understated.

4.3: Exception Based Processing-Denied Claims

- Identify the different types of health plan claim rejections and typical reasons for denials.
- Recognize the practices used to reduce or eliminate rejection and denials.
- Distinguish the two different types of appeals.
- Identify the 5 levels of the Medicare fee-for-service appeal process.

Rejections

- A claim is rejected when the health plan cannot process the claim for payment for any number of reasons.
  - Patient cannot be identified
  - Patient ineligible for coverage
  - Non compliance with billing requirements



Denial Types

- Technical
- Clinical
- Underpayment

Outpatient Denials

- Duplicate claims
- Missing authorizations
- Wrong insurance plan code
- Non covered setting
- Medicare Secondary Payer Issues
- Not medically necessary
- Overlapping IP and OP claims
- Untimely filing

Inpatient Denials

- Billed as OBS but should be IP
- Documentation does not support medical necessity
- Admission Notification not done timely
- Care not supported by medical documentation
- Focused reviews on use of OBS and anesthesia and other areas

Denials Across the Revenue Cycle

- Pre- Service Denials
- Time of Service Denials
- Post Service Denials

Recovery Audit Contractors

- Protect Medicare from fraud
- Identify improper payments
- Request and analyze claim documentation

Managing Denials

- Recognize how much they impact the revenue cycle
- Reports are essentials tools that include denial type, source, and frequency
- Focus on the analysis to make process changes to eliminate future denials.

Denial Prevention

- Financial Clearance Processes
- Clinical Documentation
- Coding accuracy
- Pre-bill edits

Appealing Denials

- Two types
  - Beneficiary
  - Provider

- Waiver of liability-provision of Medicare

Medicare Appeal Process

- Redetermination
- Reconsideration
- Administrative Law Judge
- Appeals Council
- Judicial review

Non Government Claim Denials

- Health Insurance Policy

- Contractual Requirements
  - Appeal timeframes
  - Appeal levels
  - Non appealable denials

- HIPAA requirements

Which option is NOT a type of denial?

- Technical
- Contractual Adjustment
- Clinical
- Underpayment

Key Points

- Providers must implement denial appeals when health plans have incorrectly denied or incorrectly paid claims.
- Beneficiary Appeals and Provider Appeals are the two types of appeals

Questions?

4.4: Exception Based Processing-Non-Paid Claim

- Identify the steps involved in health plan and liability payers (third-party payers) follow up and account resolution.
- Recognize liability payers and lien types used to secure payment of a debt or action.

Follow-Up Work Flow

- Refer to the electronic work list
- Clean claim payment cycle should be determinate for all major health plans.
- Effective receivables management includes analyzing the billing and collection process and eliminating unnecessary steps and system delays.

Effective Follow Up Methods

- Health Plan Electronic Claim Status
- Clearinghouse claim tracking
- Medicare Common Working File

Effective AR Management

- Prioritize Follow-up
- WIP Reports
- Payment Turnaround Techniques
- Key Focus Areas

Liability Payers

- Workers' compensation
- Automobile medical insurance
- Premises medical coverage
- *Subrogation* refers to the health plan potentially processing a claim for reimbursement and subsequent pursue payment from the liability payer.
- Types of liens can include agreement, judicial and statute.

Key Points

- The third-party payer follow-up and account resolution activities include generating a real-time electronic work list after untimely payments; comparison of actual and expected reimbursements; adjustments posts; submitting secondary claims if necessary.
- Based on an organization's policy, an unpaid clean third-party claim may become the patient's responsibility a specific number of days from the initial bill day unless prohibited by a managed care contract or applicable state and/or federal regulations.
- Work flow (Payment Cycle) – The clean claim payment cycle should be determined for all major health plans and if timely payments are not received (e.g. Medicare pays clean claims within 14 days), a real-time electronic work list should be queued to initiate immediate follow-up.

Which option is NOT a lien type?

- Agreement
- Judicial
- Subrogation
- Statutory

Questions?

4.5: Self-Pay Follow-Up

- Identify the process used to determine a patient balance bill after insurance, including contract issues and limitations.
- Recognize the difference between financial assistance and bad debt.
- Identify the key elements of a comprehensive financial policy.
- Identify the factors considered in self-pay follow-up and account resolution.

Patient Open Balance Billing

- An open balance may include a deductible, co-payment, and/or co-insurance balances.
- Processed according to patient liability guidelines
  - Disputes between the patient and the responsible insurance carrier resulting in undue or unreasonable delays, or refusal of payment, will become the responsibility of the patient for full and prompt payment according to patient liability billing and follow-up guidelines.

Financial Assistance Policy

- Key Elements:
  -Concise mission statement
  -Clearly defined financial assistance statement
  -Payment requirements
  -Inpatient and outpatient deposit requirements
  -Payment methods
  -Installment arrangement guidelines
  -Guidelines for bad debt or previous unpaid accounts

The Difference Between Bad Debt and Financial Assistance (Charity Care)

- **Bad Debt** is the unwillingness to pay the entire account or the balance of an account not paid by insurance.
- **Financial Assistance** is the inability to pay.

Self-Pay Follow-Up and Account Resolution Factors

- Poverty Guidelines
- Financial Profile
- Writing Off an Account
- Deemed Financial Assistance Eligible
- Presumptive Financial Assistance Determination
- Catastrophic Financial Assistance Accounts
- Medicare Bad Debt Accounts
- Uninsured and Underinsured
- FAP Requirements

What is not a component of a FAP?

- Mission Statement
- Payment Methods
- Registration Record
- Installment arrangement guidelines

Which option does NOT have to be considered in self pay follow up guidelines?

- Financial Profile
- Presumptive Financial Assistance Determination
- Poverty Guidelines
- Patient Open balance billing.

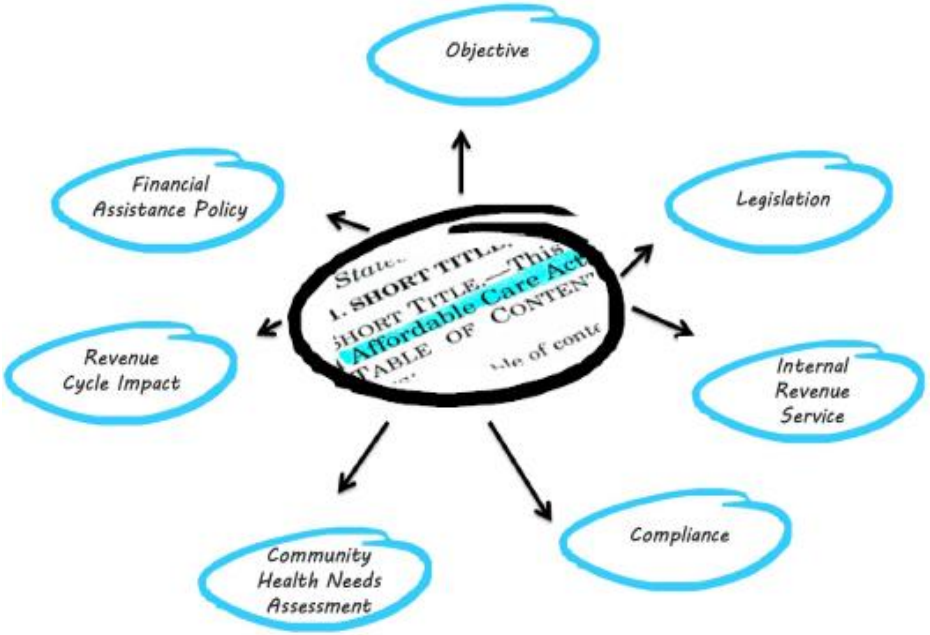
Key Points

- If there is a remaining open balance after all insurance payments have been received and posted, any remaining account financial liability is shifted to the patient. An open balance may include a deductible, co-payment, and/or co-insurance balance.
- A board-approved financial assistance policy is a fundamental requirement for correctly identifying charity and bad debt accounts.
- The definition for recognizing the difference between financial assistance and bad debt is often cited as the inability to pay (financial assistance) versus the unwillingness to pay the entire account or the balance of an account not paid by insurance (bad debt).
- The ACA requires the IRS to issues to implement the FAP sections of the ACA.

4.6: 501(r)

- Recognize the requirements of the 501(r) regulation.
- Recognize allowable billing and collection activities for tax exempt providers.
- Recognize the requirements for financial assistance policies required under 501(r).

Affordable Care Act



Extraordinary Collection Actions

- Four types of actions categorized as ECAs:
  - Legal Actions
  - Selling the Debit
  - Reporting to Credit bureaus
  - Deferring or denying medically necessary care
- Reasonable Efforts
- FAPs and ECAs

Review your knowledge

- Which option is NOT a required component of a FAP?
  1. Eligibility criteria
  2. Application process
  3. Application assistance
  4. Out-of-network providers

Key Points

- The ACA lays out requirements for community health needs assessments, policies related to financial assistance, emergency medical care, and billing and collections activities.
- The ACA must be met by all hospitals legally designated as non-profit under the IRS code 501c3 regulations.
- Final regulations under 501r apply to tax years beginning December 29, 2015.
- Compliance with 501r is required in exchange for federal tax exemption.

Questions?

4.7: Patient Debt Regulations

- Identify the four major titles of the Consumer Protection Credit Act that deal with the granting of credit.
- Recall the three types of bankruptcy governed by the 1979 Bankruptcy Act.
- Recognize the components of the Telephone Consumer Protection Act.

Granting Credit

- Consumer Credit Protection Act
  -Title I Truth in Lending Act
    - Regulation Z
  -Title III Restrictions on Garnishment
  -Title VI Fair Credit Reporting Act
  -Title VIII Fair Debt Collection Practices Act
- Consumer Financial Protection Bureau

Bankruptcy

- Chapter 7 Straight Bankruptcy
- Chapter 11 Debtor Organization
- Chapter 13 Debtor Rehabilitation

Telephone Consumer Protection Act

- Providers must implement procedures to obtain the patient's consent to call his/her cell phone number.
- The recommended best practice is to obtain express written consent from all patients to allow the use of cell phone for contact from the hospital and any of its related parties and vendors.

Review your Knowledge

- Which option is NOT a bankruptcy type?

1. Straight bankruptcy
2. Debtor reorganization
3. Creditor priority
4. Debtor rehabilitation

Key Points

- Various federal acts were passed to ensure consumers are treated fairly in credit and debt collection transactions.
- Patient accounting staff should be aware of the various acts discussed in this course.
- Management must ensure that staff and outside vendors alike follow the requirements of the various acts routinely. Failure to do so could result in large fines and adverse publicity, as well as dissatisfied patients.

Questions?

4.8: Medical Account Resolution

- Identify HFMA's best practices in medical account resolution.
- Distinguish key elements to consider when evaluating a collection agency.
- Determine the advantages of using a third party collection agency.
- Identify the purpose of a law firm in medical accounts resolution.

HFMA's Best Practices

- Make bills patient-friendly
- Establish procedures and ensure that they are followed
- Be consistent
- Coordinate account resolution activities within business affiliates
- Exercise sound business judgment when choosing account resolution methods
- State the account resolution clock when the first statement is sent
- Report back to credit bureaus when account is solved
- Track all consumer complaints

Collection Agencies

- Selection is similar to an affiliation with a business partner or hiring a vendor
- The agency represents the provider
- Communication with the patients has a significant impact
- Second Placements
- Legal Action

Evaluating a Collection Agency

- Reputation
- Patient Relations
- Agency Fees
- Retention and Payment of Agency Fees
- Reports
- Collection Results
- This same criteria applies to using a law firm.

Review Your Knowledge

- Which evaluation criteria demonstrates reputation expectations?

1. The agency's Yelp score and consumer comments.
2. The amount of monies collected monthly.
3. The employment of staff who have documented experience working in financial areas of health care
4. The high turnover rate for entry level employees.

Key Points

- Collection agencies have tools and technologies that are effective in pursuing aged self-pay accounts
- Collection agencies may collect appropriately assigned accounts faster than the provider
- Collection agencies can establish a complete documentation record that may be critical in litigation activities
- Collection agencies can provide additional benefits to the patient accounts staff through feedback on evaluation of assigned accounts and staff training
- The assignment of accounts to an agency will provide an incentive to patients to pay accounts timely to the provider and avoid transfer agency transfer
- The selection of a collection agency is similar to an affiliation with a business partner or the hiring of a vendor for specific services

4.9: Outsourcing

- Recognize the role of outsourcing within a health care organization.
- Determine the advantages and disadvantages of outsourcing.
- Identify the clauses that should be included within an outsourcing contract.

Outsourcing Within the Revenue Cycle

- Patient Access
  -Call center vendor
- Health Information Management
  -Transcription, coding, release of information processing
- Patient Accounting
  -Call center for processing of insurance and self-pay account follow-up

Outsourcing

- Advantages:
  -Qualified staff
  -Access to technology
  -Vendor absorbs some of the financial risk
  -Vendor's economies of scale helps keep costs down
- Disadvantages:
  -Impact on direct control of A/R
  -Impact on customer service
  -Increased cost if vendor is not effective
  -Legal considerations if vendor's staff do not identify themselves as vendors

Outsourcing Considerations

- Initiate an RFP process
- Require vendors to demonstrate expertise and ability to handle the outsourced processes
- Providers should be able to conduct on-site visits and obtain detailed references
- Talk with the vendor’s employees to assess level of experience and competency
- Outsourcing Contract Clauses

Review Your Knowledge

- Which function within the revenue cycle is NOT a good candidate for outsourcing?

1. Health Care Patient Services
2. Patient Accounting
3. Patient Access
4. Health Information Management

Key Points

- Before considering outsourcing as a solution, it should be evaluated in the same way as any other purchased service.
- To get the best outsourcing experience, providers should talk with the vendor's employees prior to selection, so that their level of experience and competency with both the revenue cycle and handling outsourced accounts can be determined. Reaching out to current and past vendor clients and discussing service and performance is also recommended.

Questions?

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